U.S. Department of Labor

Office of Administrative Law Judges
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Issue Date: 26 August 2003

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In the Matter of

ROBERT YOST,
Claimant

Case No. 2000-BLA-501

v.

CONSOLIDATION COAL COMPANY,
Employer

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS,
Party-in-Interest
.....

Appearances:

Robert N. Yost
Pro Se Claimant

Douglas A. Smoot, Esq.
Mary Rich Maloy, Esq.
Jackson and Kelly PLLC
For the Employer

Douglas N. White, Esq.
Office of the Solicitor
For the Director, OWCP

Before: Alice M. Craft
Administrative Law Judge

DECISION AND ORDER ON REMAND

This proceeding arises from a claim for benefits under the Black Lung Benefits Act, 30 U.S.C. § 901 et seq. The Act and implementing regulations, 20 CFR Parts 410, 718, 725 and 727,

provide compensation and other benefits to living coal miners who are totally disabled due to pneumoconiosis and their dependents, and surviving dependents of coal miners whose death was due to pneumoconiosis. The Act and regulations define pneumoconiosis, commonly known as black lung disease, as a chronic dust disease of the lungs and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment. 30 U.S.C. § 902(b); 20 CFR § 718.201 (2003). In this case, the Claimant, Robert N. Yost, alleges that he is totally disabled by pneumoconiosis.

PROCEDURAL HISTORY

This duplicate claim was filed on June 25, 1999. DX 1. On December 29, 1999, the District Director initially determined that the Claimant was entitled to benefits under the Act. DX 18. The Employer contested liability and requested a formal hearing before the Office of Administrative Law Judges. DX 19. The claim was referred to the Office of Administrative Law Judges for hearing on February 29, 2000. DX 26. The Claimant requested a decision on the record, and the Employer did not object. On August 10, 2001, I issued a Decision and Order Denying Benefits. I found that the Claimant had filed a timely duplicate claim, that he had 23 years of coal mine employment, and that Consolidation Coal Company was appropriately named as the Responsible Operator. I also found that the Claimant had established a material change in conditions, in that since denial of his previous claim, the Claimant had established that he has a pulmonary impairment which is totally disabling. I also found, however, that the Claimant had failed to establish the existence of pneumoconiosis, and denied benefits.

The Claimant appealed the decision to the Benefits Review Board. In a decision issued July 24, 2002, the Board affirmed in part, vacated in part, and remanded the case to me for further consideration. The Board affirmed my findings that the Claimant had established a material change in conditions, and that the Claimant had not established the existence of pneumoconiosis by x-ray evidence, biopsy or autopsy, or the statutory presumptions arising under 20 CFR § 718.202(a)(4). It held, however, that I had erred by weighing separately the previously submitted medical opinion evidence and newly submitted medical opinion evidence as to the existence of pneumoconiosis. The case was remanded with instructions that I conduct my own independent evaluation of the previously submitted medical opinion evidence and consider whether all the medical opinion evidence of record, when weighed together, is sufficient to establish the existence of pneumoconiosis pursuant to 20 CFR § 718.202(a)(4). The Board further instructed that if I find the medical opinion evidence sufficient to establish the existence of pneumoconiosis pursuant to 20 CFR § 718.202(a)(4), then I must weigh all the evidence relevant to 20 CFR § 718.202(a)(1), (a)(2) and (a)(4) together in determining whether claimant suffers from pneumoconiosis. Finally, the board instructed that should I find the evidence sufficient to establish the existence of pneumoconiosis pursuant to 20 CFR § 718.202(a), I must consider whether the evidence is sufficient to establish that the pneumoconiosis arose out of coal mine employment and whether the pneumoconiosis is totally disabling.

As noted above, in my initial Decision and Order Denying Benefits, and affirmed by the

Board, I found the x-ray evidence insufficient to establish the existence of pneumoconiosis.[1] In accordance with the order of the Board, the medical opinions I have considered here include those of all the doctors who examined Mr. Yost, or reviewed his medical records, and gave an opinion whether he has pneumoconiosis, other than those who based their opinions solely on his x-rays. For the reasons stated below, I find that all the medical opinion evidence of record, when weighed together, is not sufficient to establish the existence of pneumoconiosis pursuant to 20 CFR § 718.202(a)(4).

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Medical Opinions that the Claimant Has Pneumoconiosis

Dr. Abernathy

Dr. Robert Abernathy examined Mr. Yost for the Department of Labor on October 11, 1979. He took a history of Mr. Yost's coal mining work, as well as a family and individual health history, and administered ventilatory and arterial blood gas studies. Mr. Yost reported a history of attacks of wheezing. He reported smoking 3 cigarettes a day, after smoking fifteen years, stating that he cut down on his smoking in the previous three years. Dr. Abernathy stated that the present symptoms of Claimant's illness were some wheezing, dyspnea, and chest pains. Claimant did not report taking any medications. Dr. Abernathy's diagnosis was probable coal workers' pneumoconiosis related to coal mine dust exposure. DX 22-12.

Dr. Taylor

On May 17, 1985, Dr. J. Brookins Taylor examined the Claimant for the Department of Labor. The examination report indicated that Mr. Yost's work history was unavailable. During this examination, Claimant reported having wheezing attacks and smoking 1/10 of a pack per day, having smoked for twenty years. Dr. Taylor diagnosed black lung related to coal dust exposure, without further explanation. DX 23-8.

Dr. Rasmussen

Dr. D. L. Rasmussen examined Mr. Yost several times between 1973 and 1991.

On October 22, 1973, Mr. Yost reported he had been employed in the coal mining industry for 14 years, and that he first noted effort dyspnea about three years before. He also reported a chronic productive cough and episodes of wheezing. He reported smoking one-half pack of cigarettes daily for 20 years. Ventilatory studies were normal. Resting arterial oxygen

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[1]Although there were three early x-rays read only as positive (x-rays taken April 20, 1973, DX 23-11, October 22, 1973, DX 22-15, and November 11, 1976, DX 22-16), all of the x-rays taken thereafter from 1979 to 1999 were read only as negative, or as positive by one, but negative by three to nine other radiologists and B-readers, with one exception (the May 17, 1985 x-ray was read as positive by one reader, DX 23-12, and negative by another, DX 23-13).

tension was minimally reduced, but he showed an abnormal response with exercise. Dr. Rasmussen could not separate pulmonary from extra-pulmonary factors. DX 23-16, 22-13. An x-ray taken at Dr. Rasmussen's request was read as positive for pneumoconiosis by Dr. Charles Nelson (qualifications unknown). DX 22-15.

The next examination by Dr. Rasmussen took place on November 11, 1976. DX 23-16, 22-10. During this examination, Claimant reported that he first noted effort dyspnea approximately seven years before. Claimant also reported that he had chronic, productive cough, episodes of wheezing and a twenty year one-half pack per day smoking history. Dr. Rasmussen noted that Claimant's ventilatory studies revealed moderate obstructive insufficiency. He stated that Claimant's maximum breathing capacity was markedly reduced. He noted, however, that Claimant's resting arterial oxygen tension was normal. After exercise, Dr. Rasmussen noted that Claimant's total volume of ventilation was minimally in excess of that required for this metabolic level. He stated Claimant's heart rate and intrapulmonary oxygen transfer were normal. Moreover, Dr. Rasmussen stated that Claimant would appear to be capable of performing steady work at light levels. Dr. Nelson again read an x-ray taken at Dr. Rasmussen's request to be positive for pneumoconiosis. DX 22-16.

Dr. Rasmussen saw Mr. Yost again on October 5, 1982. He performed an examination, ventilatory studies and arterial oxygen studies at rest and with exercise. In his summary, Dr. Rasmussen stated that the Claimant had had progressive effort dyspnea for 10 years, increasing in the past 2 years, minimal cough and occasional episodes of wheezing. He had smoked one-half pack of cigarettes daily for 20 years, smoking only 3 cigarettes daily for the past 2-3 years. Studies revealed minimal impairment in respiratory functional capacity with reduced ventilatory capacity, reduced gas exchange, reduced single breath DCO at rest and minimal impairment in gas exchange during graded exercise. He characterized the studies as essentially unchanged since November 11, 1976. An x-ray was read as positive for pneumoconiosis by Dr. Maurice Bassali, qualifications unknown.[2] DX 23-16.

Dr. Rasmussen performed an examination on behalf of the Department of Labor on January 28, 1991. DX 24-11. He took occupational and medical histories, and conducted a physical examination and pulmonary function and blood gas studies. The pulmonary function study showed minimal, partially reversible restrictive and obstructive ventilatory impairment. The arterial blood gas showed minimal hypoxia. A chest x-ray taken that day was read as positive for pneumoconiosis by Dr. Speiden, a board-certified radiologist and B-reader.[3] DX 24-14. Dr. Rasmussen diagnosed coal worker's pneumoconiosis from coal mine dust exposure, and chronic bronchitis from coal mine dust exposure and cigarette smoking. DX 24-11.

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[2]Three board-certified radiologists, two of whom are also B-readers, later read the x-ray to be negative. DX 23-18, 23-19.

[3]Six other dually-qualified radiologists and a B-reader later read the x-ray to be negative. DX 24-26, 24-40.

Dr. Forehand

On July 28, 1999, Dr. J. Randolph Forehand examined the Claimant on behalf of the Director. Dr. Forehand's examination included the taking of medical, family, and occupational histories; a physical examination; a chest x-ray; a vent study; an arterial blood gas study; and an EKG. DX 8. Dr. Forehand read the chest x-ray as negative for opacities, but noted pleural thickening. DX 8, 10. Based on the Claimant's history, pulmonary function studies, and physical examination, Dr. Forehand concluded that the Claimant had both coal workers' pneumoconiosis and chronic bronchitis. The etiology for these conditions was the Claimant's exposure to coal dust as a roof bolter and his cigarette smoking. Dr. Forehand felt that the Claimant had a significant respiratory impairment which did not leave him with sufficient ventilatory capacity to return to his last coal mine employment; the Claimant was permanently and totally disabled. According to Dr. Forehand, the Claimant's 28 years of exposure to coal dust and silica, and in particular his work as a roof bolter, which results in the highest risk of developing Coal workers' pneumoconiosis, contributed to his impairment, as did his cigarette smoking, which impairs the clearance of dust from the lungs and damages the airways. DX 8. After another pulmonary function test administered on August 18, 2000, Dr. Forehand confirmed in a letter to Mr. Yost his opinion that Mr. Yost was disabled from his last coal mine employment. CX 1.

Medical Opinions that the Claimant Does Not Have Pneumoconiosis

Dr. Palte

Dr. Stephen B. Palte examined the Claimant for the Employer on June 11, 1991, DX 24-25, and was deposed on June 29, 1999, DX 24-43. Dr. Palte is board-certified in internal medicine, and works in private practice in the emergency room at Humana Hospital. He treats many individuals with chronic lung diseases in the emergency room, the majority of whom are coal miners or former coal miners. At the time of the evaluation, Mr. Yost told Dr. Palte he had had shortness of breath for 15 to 18 years, and was restricted to walking about an eighth of a mile on level ground. He reported coughing a little every day, but said he did not produce any sputum. He reported smoking one or two cigarettes a day, having smoked half a pack a day for 20 years, cutting down about 5 years before the examination. He gave an occupational history of working 25 years in the mines. Dr. Palte performed a physical examination and administered pulmonary function and arterial blood gas tests. Dr. Palte interpreted the pulmonary function study to show a moderate obstructive defect. The blood gas study was normal. A blood count was normal, and was not elevated as he said might occur with significant lung disease with longstanding hypoxia. An x-ray was also taken, which was interpreted by Dr. Stewart, a B reader, who did not diagnose pneumoconiosis.

Based on the history, the physical examination and the tests, Dr. Palte said Mr. Yost had a mild respiratory impairment which he thought was due to chronic cigarette smoking rather than coal dust exposure. *See also* his letter dated July 25, 1991, in DX 24-26. Dr. Palte testified that pneumoconiosis generally causes a restrictive impairment. He said the most common obstructive disease, chronic obstructive pulmonary disease, results from cigarette smoking.

Dr. Hippensteel

On May 15, 2000, Dr. Kirk E. Hippensteel examined the Claimant on behalf of the Employer. Dr. Hippensteel is board-certified in pulmonary disease and internal medicine and is a B-reader. Dr. Hippensteel examined the Claimant and took a medical, occupational, and family history. A chest x-ray, pulmonary function studies, arterial blood gas studies and an electrocardiogram were conducted. The x-ray showed a minimal increase in interstitial lung apices, and blunting at the costophrenic angle; it did not indicate pneumoconiosis. He felt that the Claimant exhibited suboptimal peak effort on his spirometry, and thus the values were an underestimate of his true function. The Claimant's lung volumes indicated air trapping with no restriction, and the marked variability in tidal volumes and effort on the MVV made the MVV invalid. His diffusion was normal, and his arterial blood gas studies showed normal gas exchange. His carboxyhemoglobin level was elevated to a level consistent with a one-pack-per-day smoking habit, indicating that the Claimant had understated the extent of his smoking habit. His exercise blood gas levels were normal. The EKG showed a nonspecific ST-T wave abnormality inferiorly.

Based on this examination and the data obtained, Dr. Hippensteel found insufficient evidence to diagnose coal workers' pneumoconiosis. The extent of the Claimant's obstructive disease could not be determined because of his suboptimal effort on the tests. The Claimant had no diffusion or gas exchange impairment, though he did have "a small amount of obstructive lung disease without any restriction that is likely related to his continuing smoking habit and is unrelated to his prior coal dust exposure." Dr. Hippensteel was unsure if the Claimant's pulmonary impairment would prevent him from performing heavy manual labor. Dr. Hippensteel did not think the Claimant had industrial bronchitis, and felt that his periodic bronchitis episodes were related to his smoking. His musculoskeletal impairment from his leg injuries would add to his impairment as a whole man. EX 4.

Dr. Hippensteel reviewed additional medical records dating from 1964 forward, and concluded that his own findings were valid. He found that the Claimant's function had worsened since leaving the mines, based on the Claimant's continued smoking. He could not be sure of the extent of the deterioration because of lack of valid efforts on the pulmonary function tests. Weighing against a finding of coal workers' pneumoconiosis were the lack of gas exchange or diffusion impairment, the temporal correlation between his impairment and his smoking, and the partial reversibility of the Claimant's impairments. He would find that the Claimant did not have coal workers' pneumoconiosis even if the chest x-rays were positive. While Dr. Hippensteel could not say whether from a pulmonary standpoint the Claimant could return to work in the mines, he did think that the Claimant had not suffered an impairment from his coal dust exposure that would prevent him from returning to the mines. His impairment arose from his continued cigarette smoking. EX 4.

Dr. Hippensteel was deposed on July 11, 2000. In preparation for the deposition, Dr. Hippensteel reviewed the reports of Drs. Fino, Loudon and Morgan. He also reviewed x-ray interpretations of both the April 11, 2000, and July 28, 1999 x-rays. Dr. Hippensteel summarized his findings from his evaluation of the Claimant. He noted that the Claimant's carboxyhemoglobin level did not correlate with the Claimant's reported level of smoking. The Claimant's breath

sounds showed minimal rhonchi but no rales, indicating mild airway irritation but no other findings. The Claimant's chest x-ray was insufficient to find pneumoconiosis. His interpretation of the April 11, 2000, x-ray was very close to Dr. Wiot's interpretation of that same x-ray. Dr. Hippensteel discussed Dr. Wiot's findings on x-ray, in which Dr. Wiot noted pleural disease in the left base with linear stranding consistent with a past inflammatory process. Dr. Hippensteel interpreted this finding as related to pleural changes that he had found in the left costophrenic angle. He explained that Dr. Wiot noted that this process, which is unrelated to pneumoconiosis, could have caused the changes noted in the left apex, which would also not be related to coal workers' pneumoconiosis.

Dr. Hippensteel testified that he could not get valid results for some of the pulmonary function studies. He noted a June 14, 2000, letter to the ALJ in which he discussed his inability to get valid results and the Claimant's inability to give consistent efforts, as required by the regulations. He noted that the Claimant did not give consistent efforts, as supported by the data, and did not keep his mouth sealed over a tube to accurately perform the lung volume study. He also invalidated Dr. Forehand's spirometry. He disagreed with Dr. Michos' finding that the tracings were acceptable except for a suboptimal MVV. He agreed with Dr. Morgan's findings on the subject of the pulmonary function tests. Dr. Forehand's resting arterial blood gas study showed minimal hypoxemia and a normal exercise response. Dr. Hippensteel's arterial blood gas studies showed normal gas exchange at rest and a submaximal exercise test, because the Claimant did not reach anaerobic threshold. The Claimant did not have a real drop in his pO2 level. The diffusion capacity test was valid and showed normal diffusion when corrected for alveolar volume, which is based on the quality of the breath taken for the test. It would have been higher if the Claimant did not have an elevated carboxyhemoglobin level. Emphysema causes a diffusion impairment and gas exchange impairment with exercise, so Dr. Hippensteel did not believe the Claimant had emphysema. Dr. Forehand did not do a diffusion capacity study, which Dr. Hippensteel thinks is helpful because it can differentiate between different diagnoses: coal workers' pneumoconiosis and emphysema affect diffusion, but bronchitis does not affect diffusion. In this case, the normal diffusion showed that the Claimant did not have pneumoconiosis, despite invalid spirometry.

Based on his evaluation of the Claimant and his review of the other medical reports and data, Dr. Hippensteel did not believe that the Claimant had coal workers' pneumoconiosis, as it is medically or legally defined. He also ruled out the diagnosis of industrial bronchitis, because industrial bronchitis subsides within several months of leaving the mines and because the Claimant's cough was productive of sputum less than one-fourth of the time, which does not meet the definition of chronic bronchitis. Based upon the valid data that Dr. Hippensteel had before him, he felt that the Claimant had the respiratory capacity to return to his last coal mine employment. The Claimant did have some level of obstructive disease, but the extent of this disease could not be determined. He continued to believe that the Claimant's impairment and breathing problems were caused by continued cigarette smoking, rather than by coal dust exposure, as this was supported by the valid objective medical data of record. The Claimant did not have a respiratory impairment caused by, contributed to, or aggravated by his coal dust exposure. EX 13.

In a December 4, 2000, report, Dr. Hippensteel examined additional medical records related to the Claimant, including the results of Dr. Forehand's August 18, 2000 pulmonary function test. He agreed with Dr. Forehand that the Claimant had exhibited better effort on the August 18, 2000 study, though he discussed the variability in effort shown on the test. However, the FEV_1 and FVC results for the best two efforts were within 5%. Dr. Hippensteel noted that these results were the best obtained for the Claimant and showed more reversibility post-bronchodilator. This level of improvement was indicative of an asthmatic response based on the AST criteria, which leads to another cause for his obstructive disease besides smoking. He noted that Dr. Forehand did not address the reversibility issue.

Dr. Hippensteel concluded that this pulmonary function test showed sufficient cooperation and consistency to be considered valid. He generally agreed with Dr. Morgan's assessment of the records. After reviewing all of the additional records, Dr. Hippensteel noted that they provided "useful data and corroboration of findings obtained earlier in this individual with a valid spirometry by Dr. Forehand since my examination." Based on the most recent spirometry, Dr. Hippensteel felt the Claimant had a 25% whole man impairment, which would allow him to do "periodic heavy manual labor." He found no evidence that the Claimant's impairment was due to coal workers' pneumoconiosis or dust exposure, based on the variable and partially reversible nature of his impairment. He noted that the Claimant's continued smoking and associated deterioration in function since leaving the mines without developing radiographical evidence of coal workers' pneumoconiosis were consistent with smoking and an asthmatic component, both of which have no relation to his coal mine employment. The Claimant's impairment would be the same had he never worked in the mines. EX 21.

Dr. Fino

Dr. Gregory J. Fino reviewed Mr. Yost's medical records on behalf of the Employer on three separate occasions, once in 1992, DX 24-41, and twice in 2000, EX 8 and 19. Dr. Fino is board-certified in internal medicine and pulmonary disease, and a B-reader. His initial report addressed medical reports and x-ray and test results from 1973 to 1991. He concluded that Mr. Yost did not suffer from an occupationally acquired pulmonary condition as a result of coal mine dust exposure. Dr. Fino authored a report dated June 26, 2000, EX 8, in which he summarized all of the Claimant's records and offered an opinion based on those records. Dr. Fino noted that he had authored a report dated May 21, 1992, in which he concluded that the Claimant did not have coal workers' pneumoconiosis or any other occupationally acquired pulmonary condition. He felt the Claimant had a mild, obstructive ventilatory impairment that was due to smoking rather than dust inhalation. Following his review of the new medical information in conjunction with the other medical information, Dr. Fino's opinion remained unchanged. He did not think the Claimant was disabled due to lung disease. He felt the Claimant's obstructive impairment was due to his smoking and would be the same if he had never been in the mines. EX 8. Dr. Fino authored an additional report dated December 1, 2000, in which he reviewed additional medical information and concluded that it did not change any of his previously-expressed opinions. EX 19.

Dr. Castle

Dr. James R. Castle authored a report dated December 4, 2000. EX 20. Dr. Castle is board-certified in pulmonary disease and internal medicine and is a B-reader. He reviewed the Claimant's medical records and reports from 1964 forward. Based on his review of Dr. Forehand's July 28, 1999, examination and testing, Dr. Castle concluded that the spirometric tests were invalid because of less than maximal effort as shown in the peak flows. In his review of Dr. Hippensteel's examination and report on the Claimant, Dr. Castle noted that the spirometric tests showed less than maximal effort, with a less than maximal peak flow. The degree of airway obstruction could not be quantified. Though the lung volumes showed hyperinflation and gas trapping, they might not be valid because the Claimant failed to maintain a seal. With regard to Dr. Forehand's August 18, 2000, pulmonary function study, Dr. Castle noted that the "prebronchodilator spirometry is not valid because the mouth piece was partially obstructed as though with the tongue and the patient did not exhale until plateau was reached." The post-bronchodilator study showed better effort and was probably valid. This study showed moderate airway obstruction, with partial reversibility as evidenced by the significant FEV_1 improvement post-bronchodilator. Dr. Castle concluded that the Claimant does not have coal workers' pneumoconiosis. The Claimant's risk factors were coal mining, tobacco abuse, and coronary artery disease. He noted the variability in the Claimant's self-report of smoking history and concluded that the carboxyhemoglobin levels found by Dr. Rasmussen and Dr. Hippensteel supported a finding that the Claimant was smoking at least a pack of cigarettes daily. He noted that the Claimant's x-rays were interpreted by the vast majority of readers as showing no evidence of coal workers' pneumoconiosis. He concluded that the physiological studies showed valid evidence of initially mild airways obstruction after leaving the mining industry, with an increase to moderate, partially reversible airway obstruction while continuing to smoke; this was not consistent with coal workers' pneumoconiosis. He stated:

> When coal workers' pneumoconiosis causes impairment it does so by causing a mixed, irreversible obstructive and restrictive ventilatory defect. The fact that he has no restriction and significant airway reversibility clearly mitigates against this being due to coal workers' pneumoconiosis. This also has developed in the absence of further coal mining employment, but in the presence of an ongoing tobacco abuse habit. This is absolutely typical findings of someone who has tobacco smoke induced chronic obstructive pulmonary disease.

He noted that the ABGs have all shown either normal results or very mild hypoxemia at rest with improvement to normal levels with exercise; the Claimant did not have an abnormal gas transfer mechanism. For all of these reasons, Dr. Castle concluded that the Claimant did not have coal workers' pneumoconiosis, based on the radiographic findings, the physiologic findings, and the arterial blood gas findings. He concluded that the Claimant had a moderate degree of airway obstruction that was not related to coal mine employment or coal dust exposure but was a result of the Claimant's cigarette smoking-induced COPD. The August 18, 2000 pulmonary function tests were probably valid and showed that the Claimant "would not retain the respiratory capacity to perform his usual coal mining employment duties"; however, this was not due to coal mine employment or dust exposure, but rather was due to smoking. Even if the Claimant were

determined to have "radiographic evidence of minimal, simple coal workers' pneumoconiosis," Dr. Castle's opinions regarding the Claimant's impairment would not change because his opinion was not based on the x-rays but on the physiological findings. EX 20.

Dr. Castle was deposed on January 3, 2001. EX 23. He did not examine the Claimant, but he had extensive data to review. Based on the Claimant's statement while hospitalized, Dr. Castle felt the Claimant had at least a 40-pack-year smoking history, which could cause pulmonary problems such as chronic obstructive pulmonary disease (emphysema and/or chronic bronchitis) and lung cancer, as well as arteriosclerotic cardiovascular disease, peripheral vascular disease and cerebral vascular disease. Upon leaving the mines, the Claimant had mild airway obstruction based on valid pulmonary function tests. The Claimant continued to smoke, and has developed moderate, partially reversible airway obstruction, based on part of the August 2000 pulmonary function test. While Dr. Castle found that the post-bronchodilator pulmonary function test in August 2000 was valid, he did not know if the improvement in the FEV_1 was due to effort or reversibility. Because of the invalid prebronchodilator study, asthma could not be diagnosed. He found Dr. Hippensteel's pulmonary function study invalid. The Claimant's blood gases were normal at rest and after exercise. The Claimant had a carboxyhemoglobin level of 4.8% at that time, indicating the Claimant smoked one pack of cigarettes per day. Dr. Hippensteel's data did not show a restrictive impairment: the lung volumes showed hyperinflation and gas trapping, which is the opposite of restriction, and which is consistent with smoking-induced COPD.

Dr. Forehand's 1999 pulmonary function studies were invalid based on submaximal efforts as noted on the peak flows, though there was some degree of reproducibility. Dr. Forehand's blood gas studies showed hypoxemia at rest, with normal levels after exercise. This was not consistent with coal workers' pneumoconiosis, which causes irreversible hypoxemia, but was consistent with tobacco-smoking induced chronic obstructive pulmonary disease. The pulmonary function studies showed reversibility. Coal workers' pneumoconiosis leads to irreversible scarring and would not allow for improvement post-bronchodilator. Dr. Castle noted that the Claimant's x-rays did not show this scarring, though Dr. Castle did not read the x-rays himself. He did review the interpretations, the vast majority of which were negative for pneumoconiosis. Cigarette smoking may not cause any x-ray abnormalities, or it may cause changes from chronic bronchitis, which are seen as irregular opacities in the lower lung zones and read as 0/1 or 1/0, and emphysema. It is possible to have pneumoconiosis that is not radiographically present, but that would show up on a biopsy. However, "[i]n that circumstance, it would show up on a biopsy but would not be of significant enough profusion to be seen radiographically or to cause any significant respiratory abnormalities from a physiologic standpoint." Dr. Castle reviewed the physiologic and radiographic findings and found nothing to support a finding that the Claimant's impairment was due to coal mine dust exposure. He concluded that the cause of the impairment was tobacco smoke-induced airway obstruction. Dr. Castle was familiar with the definition of legal pneumoconiosis, and felt that the Claimant did not have it. His pulmonary function studies and other objective tests were consistent with other patients with similar smoking histories who had never been exposed to coal dust. He did not believe the Claimant retained the respiratory capacity to do his last coal mine employment, because his function would not allow heavy manual labor on a regular basis. However, this disability was completely due to his tobacco smoking habit. The Claimant would be in the same condition had he never been a miner. EX 23.

Dr. Morgan

Dr. W.K.C. Morgan authored a report dated June 27, 2000, in which he summarized and discussed all of the Claimant's medical records. EX 9. Dr. Morgan is a B-reader and has held various academic posts in pulmonary disease and occupational medicine. He concluded that the Claimant had mild to moderate airways obstruction that had increased in the past ten years, gradually worsening to at least a moderate level. The Claimant had not used maximal effort on the majority of the pulmonary function studies over the years. The lower values could not be attributed to a lack of understanding or to a disease, since subsequent tests "have been better making it quite apparent that he has not cooperated." However, the Claimant had impaired lung function, but relatively normal arterial blood gases and diffusing capacity. The Claimant's impaired lung function was a result of emphysema and small airways disease caused by his smoking.

Dr. Morgan noted the Claimant's inconsistent statements regarding his smoking history. In 1991, Dr. Rasmussen had found a carboxyhemoglobin level of over 6.5%[4], indicating that the Claimant had smoked at least 1.5 packs of cigarettes daily at that time. Dr. Hippensteel's recent evaluation of the Claimant showed a 4.8% carboxyhemoglobin level. Dr. Morgan concluded that the Claimant had long-standing cigarette smoking history that had led to his airways obstruction. Dr. Morgan found that the Claimant's chest x-ray did not show Coal workers' pneumoconiosis. According to Dr. Morgan, x-ray categories correlate directly with the amount of coal dust deposited in the lungs, with a higher x-ray category indicating the presence of more dust. Therefore, a finding of 0/1 would indicate very little dust in the lungs, which would have no effect on the Claimant's lung function. He concluded that there was insufficient objective evidence to diagnose coal workers' pneumoconiosis. The Claimant had a moderate pulmonary impairment from his cigarette smoking, not from coal mining. Even if the Claimant were found to have simple coal workers' pneumoconiosis, he would find that the Claimant's symptoms were not related to the coal workers' pneumoconiosis. EX 9.

On November 15, 2000, Dr. Morgan reviewed additional medical opinions and evidence and concluded that his findings in his prior report still stood. EX 17. He agreed with Dr. Hippensteel's June 14, 2000, remarks concerning the validity of some of the pulmonary function studies. He discussed Dr. Hippensteel's July 11, 2000, deposition testimony, noting that the Claimant's arterial blood gas studies taken during exercise involved limited exercise. Dr. Morgan opined that with mild to moderate obstruction, the Claimant should have been able to exercise longer. This is further supported by the Claimant's lack of heart disease and his normal diffusion capacity, with normal gas exchange. While coal workers' pneumoconiosis can affect diffusing capacity, the impairment is usually mild, and the patient's diffusing capacity improves on exercise because of better matching of the ventilation and perfusion, except in cases of category 3 pneumoconiosis.

He agreed with Dr. Fino's June 26, 2000, findings regarding the medical information. He

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[4]Dr. Morgan noted that Dr. Rasmussen had not referenced the Claimant's carboxyhemoglobin levels in his report, but the level was included with his records.

noted that the improvement on the FEV_1 and FVC from July 28, 1999, to April 2000, could not be attributed to asthma, since the Claimant had never been found to have it, but was instead due to improved effort. Lung function does not improve with age. He agreed with Dr. Stewart's conclusions as contained in his report dated July 19, 2000. Dr. Morgan disagreed with Dr. Stewart's statement in his July 24, 2000, deposition that administration of the bronchodilators explained the difference between the FEV_1 and FVC measurements by Dr. Forehand and Dr. Hippensteel. Rather, he felt the difference should be attributed to better effort. He noted that the reversibility of COPD-related obstruction is relatively small. This position was further supported by the normal diffusing capacity in the face of an FEV_1 of 1.30; if the Claimant's FEV_1 was really that low, the Claimant's diffusing capacity should only have been approximately 50% of predicted. However, he noted that Dr. Stewart had later acknowledged that the disparity between the FEV_1's could be explained by poor effort.

As discussed in Dr. Wiot's July 19, 2000, deposition, Dr. Morgan had noted x-ray changes that occur in older, heavy smokers. Irregular opacities are sometimes found in the lower lung zones and are scanty: they do not resemble coal workers' pneumoconiosis opacities.

Based on his review of the additional records, Dr. Morgan's opinions were the same as stated in his June 27, 2000 report. The Claimant had mild to moderate airways obstruction, and the increase in the obstruction over the last ten years could be accounted for by the Claimant's smoking. The Claimant would be able to carry out his last coal mining job were it not for his age. There was insufficient evidence to diagnose coal workers' pneumoconiosis, though Dr. Morgan acknowledged that he had not seen the Claimant's x-rays himself. The Claimant's mild to moderate respiratory impairment could not be attributed to pneumoconiosis or coal dust exposure. He was not totally disabled from his work, but was not suitable for employment due to age. Dr. Morgan's opinion would not change if the Claimant were found to have coal workers' pneumoconiosis. He noted that "[t]he only way it would be possible to diagnose Coal workers' pneumoconiosis was to carry out a lung biopsy, or should Mr. Yost subsequently succumb, then a postmortem examination of the lungs may show microscopic changes of simple Coal workers' pneumoconiosis. The changes of the type I have mentioned that could conceivably be found in Mr. Yost's lungs would in no way lead to respiratory impairment nor would they hasten his demise." EX 17.

On November 21, 2000, Dr. Morgan prepared another report, indicating that he had received additional records from the Claimant dated August 19, 2000. EX 17. The records contained a table from Dr. Forehand which summarized the Claimant's pulmonary function studies Based on his review of this table, he noted a significant increase in the FVC from July 1999 to August 2000, as well as a 10% increase in the FEV_1, with a larger increase of the FEV_1 in April 2000. Dr. Morgan stated that:

> [t]he decreased FVC and FEV_1 present in Mr. Yost cannot be attributed to coal workers' pneumoconiosis (CWP) or to exposure to coal dust since he stopped working in 1973, that is to say some 26 or 27 years ago.

Dr. Morgan noted that FVC and FEV_1 improvement cannot be attributed to natural variation,

because they decline with age. The medical evidence supported a diagnosis of COPD, so the improvement must be due to better effort, unless the Claimant had a reversible broncho constriction such as asthma, which is not occupationally related. The MVV was also invalid. Dr. Morgan felt the Claimant's impairment should be classified as mild to moderate based on the improvement from July 1999 to August 2000. Dr. Forehand's finding that the values on the three pulmonary function tests did not significantly differ was "completely incorrect." He noted that the improvement on administration of bronchodilators in the August 2000 test was greater than that seen in coal workers' pneumoconiosis and "would be very uncommon in COPD." He noted that any change in FEV_1 would be a large percentage change, and that the tracings were varied, inconsistent, and unacceptable. However, Dr. Morgan felt that there was "no doubt that Mr. Yost has airways obstruction which is probably mild to moderate," as demonstrated by the flow volume loop. The FVC maneuvers showed marked variability, and many of them were aborted after 6 to 7 seconds; he did not believe they complied with the Department of Labor criteria.

Dr. Morgan concluded that the tracings were not acceptable and observed that the lung volumes had increased in the past year, which occurs only in reversible disorders such as asthma. He did not believe the Claimant's efforts were consistent, based on the tracings. Even if the tracings were accepted, the impairment could not be due to coal workers' pneumoconiosis or COPD, which do not improve with time. Coal workers' pneumoconiosis also does not improve with the administration of bronchodilators, and COPD does not show that level of improvement. He attributed the Claimant's improvement in April and August 2000 to better effort on the Claimant's part. He did feel that the Claimant had mild to moderate airways obstruction due to his cigarette smoking. EX 17.

Dr. Loudon

Dr. Robert G. Loudon reviewed Mr. Yost's medical records on behalf of the Employer three times, once in 1992, DX 24-41, and twice in 2000, EX 11 and 18. Dr. Loudon is a professor of internal medicine and is the director of the Pulmonary Disease Division at the University of Cincinnati Medical Center. During his initial review, he saw records from 1964 to 1991, and concluded that there was not sufficient objective evidence to justify a diagnosis of pneumoconiosis, and that Mr. Yost had a mild degree of chronic obstructive lung disease. DX 24-41. On July 3, 2000, Dr. Loudon issued a report, in which he reviewed various reports of other doctors and the new medical evidence in this claim. He concluded that there was insufficient objective evidence to support a finding of coal workers' pneumoconiosis. The Claimant's mild degree of chronic obstructive lung disease, while possibly impairing his ability to do heavy manual labor, was not the result of occupational causes. The Claimant was not unable to do his regular coal mining work, and his degree of impairment was "probably no worse than that seen in many of his co-workers of similar age and smoking history." Because of the variability of efforts as shown in the tracings, and the marked reduction in the MVV, it would be difficult to accurately assess the Claimant's work capacity. However, whatever functional respiratory impairment the Claimant had could not be caused in whole or in part by pneumoconiosis. EX 11.

On November 29, 2000, he reviewed additional medical records and reports, and once again concluded that there was insufficient objective evidence to justify a diagnosis of coal

workers' pneumoconiosis, that the Claimant had mild obstructive lung disease which could impair his ability for heavy manual labor but which was not attributable to occupational causes, and that he was not totally disabled from his last coal mine employment. Dr. Loudon felt the Claimant had the same functional ability as his co-workers of a similar age with similar smoking histories. Any functional respiratory impairment the Claimant had was not due to pneumoconiosis, and this would be true even if the Claimant were determined to have pneumoconiosis. EX 18.

Dr. Stewart

Dr. Bruce N. Stewart first reviewed Mr. Yost's medical records on behalf of the Employer in 1992. Dr. Stewart is board-certified in internal medicine, pulmonary disease, and sleep disorders and is a B-reader. Initially he reviewed x-rays taken from 1964 to 1991, and history and physical reports, pulmonary function tests, and arterial blood gas studies administered between 1973 and 1991. He issued a report dated May 27, 1992, and gave a deposition on June 22, 1992. DX 24-41. Dr. Stewart's opinion was that Mr. Yost did not suffer from coal worker's pneumoconiosis. He did have a mild obstructive respiratory impairment based on the pulmonary function studies. Dr. Stewart said that impairments caused by smoking cigarettes could be distinguished from impairments caused by coal mine employment, because the former cause a reduced FEV_1/FVC ratio, with a normal or reduced FVC, and normal total lung capacity; while the latter will result in a normal or slightly elevated FEV_1/FVC ratio, and a reduced FVC and total lung capacity. Based on Mr. Yost's tests, Dr. Stewart concluded that his impairment resulted from cigarette smoking.

More recently, Dr. Stewart prepared a report dated July 19, 2000, and testified by deposition on July 24, 2000. In this report, Dr. Stewart reviewed his previous report, as well as other medical reports. He found Dr. Forehand's pulmonary function study valid and indicative of a moderate obstructive defect. The April 11, 2000, pulmonary function study was valid, except for the MVV, which showed marked variability indicative of submaximal efforts and which did not correlate well with the FEV_1. He felt that study showed "a moderate obstructive defect with the efforts and results after bronchodilators being somewhat worse." Dr. Stewart concluded that the Claimant did not have coal workers' pneumoconiosis, based on the fact that only one chest x-ray reading was positive and that there is no biopsy evidence. The medical evidence did show a mild to moderate respiratory impairment, though this impairment could not be attributed to coal workers' pneumoconiosis. His conclusion that the Claimant's impairment was not caused by coal workers' pneumoconiosis was based on his determination that the Claimant did not have coal workers' pneumoconiosis and the fact that "there is an adequate explanation for the impairment in the patient's long history of cigarette smoking." Moreover, he did not believe the Claimant was disabled from returning to his coal mining work. His opinions regarding the degree of the Claimant's respiratory disability would not change if the Claimant were found to have pneumoconiosis.

On deposition, Dr. Stewart reiterated that he did not believe the Claimant had coal workers' pneumoconiosis, based on his review of the x-rays, the lack of biopsy evidence, and the lack of a restrictive impairment or rales on examination. He did not believe the Claimant had any respiratory impairment that could be related to coal dust exposure. Dr. Stewart stated that while

there was some inconsistency on the pulmonary function study conducted by Dr. Forehand on July 28, 1999, the spirometry portion of the study was valid. He did not think the MVV portion of that study was valid, because it did not correlate well with the FEV_1 and showed variation in efforts. He felt that the difference between the July 28, 1999, FEV_1 and the FEV_1 obtained by Dr. Hippensteel nine months later was significant. This was significant because it showed a variable disease process that improved with bronchodilators. Though the Claimant's FEV_1 improved significantly after bronchodilator in Dr. Forehand's study, it did not do so in Dr. Hippensteel's study. However, he felt that these results showed a reversible component, which does not occur in coal workers' pneumoconiosis. This type of mild to moderate impairment was consistent with cigarette smoking. Dr. Forehand's ABG study showed a slightly reduced PO2 at rest, with dramatic improvement on exercise, which Dr. Stewart felt was consistent with obstructive lung disease such as cigarette smoking. Dr. Hippensteel's ABG showed a normal PO2 level, with no significant change on exercise. The normal diffusion capacity found by Dr. Hippensteel indicated that the Claimant's impairment was not due to emphysema. Dr. Stewart stated:

> [W]hat I'm saying is that this man has obstructive lung disease, not necessarily emphysema but of the chronic bronchitis type, so chronic obstructive pulmonary disease, and you can either have emphysema or chronic bronchitis, and in most cases, there is both. With this man, with a normal diffusion capacity, would indicate that his disorder is primarily chronic bronchitis.

Dr. Stewart attributed the Claimant's damaged airways and bronchial tubes and inflammation and bronchospasm to his cigarette smoking. He agreed with some of the other doctors that the efforts on some of the pulmonary function tests could have been better and that if the Claimant had given better effort on the studies done by Drs. Forehand and Hippensteel, his obstruction might have fallen within the mild range. He stated:

> [F]or me to say that a test is valid does not necessarily mean that I feel that he was giving the best effort. In fact, as I've just said, the results we see indicate that the effort was quite variable and he probably wasn't giving the best effort, but by strict criteria, if you look at the shape of the curves and you look at the absolute values, are they consistent with five percent, and that is the legal guideline that we're using for a valid study, and he did meet that criteria, but it doesn't mean that he couldn't have done better.

Dr. Stewart's understanding was that for Department of Labor purposes, there had to be three tracings, two of which came within 5% of one another.

Dr. Stewart described the Claimant's smoking history as "quite variable," but noted that the objective evidence suggested the Claimant had been smoking "up until recently when Doctor Hippensteel examined him." The 4.8% carboxyhemoglobin level found by Dr. Hippensteel would correlate to smoking 0.5 to 1.0 packs of cigarettes per day. He noted that the Claimant had consistently shown an elevated carboxyhemoglobin level. Dr. Stewart felt the Claimant had the respiratory capacity to return to his usual coal mine work, even with the levels found on the pulmonary function studies done by Drs. Forehand and Hippensteel. He felt the Claimant's obstruction was caused by his cigarette smoking. He did not believe the Claimant had any

impairment or disability caused by, contributed to, or aggravated by his previous coal mine dust exposure. EX 15.

Dr. Stewart wrote an additional report dated December 4, 2000, in which he reviewed additional medical data. With regard to Dr. Forehand's August 18, 2000, pulmonary function test, Dr. Stewart concluded that the pre-bronchodilator portion of the test was invalid because there was more than a 5% difference between two efforts. The post-bronchodilator portion of the test was valid, because there were two values within 5% of each other, and this study shows a moderate obstructive impairment. Dr. Stewart concluded that there was insufficient medical evidence to support a finding of coal workers' pneumoconiosis. He found that the Claimant had a pulmonary or respiratory impairment, but it was not caused by coal workers' pneumoconiosis or dust inhalation. It was caused by the Claimant's cigarette smoking, based on the continued elevated carboxyhemoglobin levels and the pattern of impairment on the pulmonary function testing, which is consistent with COPD. The Claimant has deteriorated in the last ten years, and is totally and permanently disabled from his last coal mine work, which involved working on the belt line and shoveling coal eight hours a day. He did not believe that this impairment was caused by Coal workers' pneumoconiosis. He maintained that it was possible to distinguish between impairments caused by Coal workers' pneumoconiosis and impairments caused by smoking, based on histories, physical examination, pulmonary function studies, and arterial blood gas studies. The Claimant's elevated carboxyhemoglobin levels indicate smoking, and his wheezes and rhonchi are consistent with COPD. The reduction of the FEV_1/FVC ratio is not caused by coal workers' pneumoconiosis. Even if the Claimant were found to have coal workers' pneumoconiosis, Dr. Stewart would still maintain his opinion regarding the Claimant's disability and its cause. EX 22.

Discussion

My specific reasons for giving greater probative weight to the opinion of Dr. Hippensteel, bolstered by the opinions of Drs. Stewart, Loudon, Fino, Morgan and Castle, over that of Dr. Forehand, were explained in detail in my previous decision. Similar reasons apply when weighing all of the medical opinions together. Those who gave opinions that Mr. Yost does not have pneumoconiosis have excellent credentials; provided more complete reasoning and explanations; based their opinions on more extensive documentation; and their opinions were in better accord with both the objective medical evidence underlying their opinions and the overall weight of the medical evidence of record.

Four doctors who have examined Mr. Yost over the years have opined that he has pneumoconiosis: Dr. Abernathy, in 1979; Dr. Taylor, in 1985; Dr. Rasmussen, in 1982 and 1991[5]; and Dr. Forehand, in 1999. None of their qualifications are explained in the record, except that Dr. Forehand is a B-reader. Although all four had some objective evidence to support their opinions, none offered a very detailed explanation of the basis for them. Their opinions were based in part on positive x-ray readings, but most of the readings now in evidence, especially for x-rays taken after 1979, are negative. Nor is there any evidence that any of the four had

[5]Although Dr. Rasmussen also examined Mr. Yost in 1973 and 1976, he did not give a diagnosis of pneumoconiosis in either of those reports.

information available to them other than their own observations when they formed their opinions, with the possible exception of Dr. Rasmussen, who examined Mr. Yost on multiple occasions. Nonetheless, even he did not have the comprehensive records available to Dr. Hippensteel and the other doctors who reviewed all the records.

Arrayed against the four opinions that Mr. Yost has pneumoconiosis, are those of two doctors who examined Mr. Yost, Dr. Palte in 1991 and Dr. Hippensteel in 2000, and five others who reviewed all of his records, Dr. Fino, Dr. Castle, Dr. Morgan, Dr. Loudon and Dr. Stewart. Dr. Hippensteel both examined Mr. Yost, and reviewed his records, an advantage not available to any of the four who found pneumoconiosis. All of the doctors who opined against pneumoconiosis have excellent qualifications. Dr. Palte is board-certified in internal medicine. However, I give little weight to his opinion, as he appeared to rule out pneumoconiosis because Mr. Yost has an obstructive, rather than a restrictive impairment. *See Warth v. Southern Ohio Coal Co.*, 60 F.3d 173, 174-175 (4th Cir. 1995). Drs. Hippensteel, Fino, Castle and Stewart are board-certified in internal medicine and pulmonary disease, and Drs. Morgan and Loudon both hold academic positions in pulmonary disease. Moreover, their opinions were consistent, that Mr. Yost's pulmonary impairment results from smoking, and not coal dust exposure. All provided detailed explanations of their reasons for their opinions consistent with the objective evidence, and with the weight of the evidence as a whole. For these reasons, I conclude that their opinions are entitled to greater weight.

Weighing all of the medical opinions together, as instructed by the Benefits Review Board, I conclude that the medical opinion evidence of record is not sufficient to establish the existence of pneumoconiosis pursuant to 20 CFR § 718.202(a)(4). Thus I need not proceed to the next steps suggested by the order of remand. Because the Claimant has failed to meet his burden to establish that he has pneumoconiosis, he is not entitled to benefits under the Act.

ORDER

The claim for benefits filed by Robert N. Yost on June 25, 1999, is hereby DENIED.

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ALICE M. CRAFT
Administrative Law Judge

NOTICE OF APPEAL RIGHTS: Pursuant to 20 CFR § 725.481 (2003), any party dissatisfied with this decision and order may appeal it to the Benefits Review Board within 30 days from the date of this decision and order, by filing a notice of appeal with the Benefits Review Board at P.O. Box 37601, Washington, DC 20013-7601. A copy of a notice of appeal must also be served on Donald S. Shire, Esq., Associate Solicitor for Black Lung Benefits. His address is Frances Perkins Building, Room N-2117, 200 Constitution Ave., NW, Washington, D.C. 20210.